

Dermatology & Advanced Skin Care
 6021 University Blvd., Suite 390 Ellicott City, MD 21043
 410-203-0607

Patient Information

Patient's Name (Last, First, Middle)			Date
			Home Phone Number
Address			Work Phone Number/Extension
City	State	Zip	Cell Phone Number
Male <input type="checkbox"/> Female <input type="checkbox"/>	Employed <input type="checkbox"/> Yes <input type="checkbox"/> No	Student <input type="checkbox"/> Yes <input type="checkbox"/> No	Preferred phone number to contact you: <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell
E-mail Address			Date of Birth / /
Employer/ School Name			Occupation
Responsible Party			Responsible Party Phone Number
Billing Address If Different Than Above			
Were you referred by a physician? <input type="checkbox"/> Yes <input type="checkbox"/> No		If so, physician's LAST NAME, FIRST NAME:	
Person to notify in an emergency		Relationship	Phone Number

Insurance Information

Primary Insurance Carrier	
Group Name or Number	ID #
Address of Insurance Company	City /State/ Zip
Primary Policyholder's Name (Last, First, Middle Initial)	Policy Holder's Date of Birth / /
Policy Holder's Employer	Is insurance through work? Yes <input type="checkbox"/> No <input type="checkbox"/>
What is your relationship to the policyholder? Circle One: I am the: Holder <input type="checkbox"/> Wife <input type="checkbox"/> Husband <input type="checkbox"/> Child <input type="checkbox"/>	Is a Referral Required? Yes <input type="checkbox"/> No <input type="checkbox"/>

Secondary Insurance Carrier	
Group Name or Number	ID #
Address of Insurance Company	City /State/ Zip
Primary Policyholder's Name (Last, First, Middle Initial)	Policy Holder's Date of Birth / /
Policy Holder's Employer	Is insurance through work? Yes <input type="checkbox"/> No <input type="checkbox"/>
What is your relationship to the policyholder? Circle One: I am the: Holder <input type="checkbox"/> Wife <input type="checkbox"/> Husband <input type="checkbox"/> Child <input type="checkbox"/>	Is a Referral Required? Yes <input type="checkbox"/> No <input type="checkbox"/>

Patient Consent for Use and Disclosure of Protected Health Information

I consent for Dermatology & Advanced Skin Care to disclose health information about me to carry out treatment, payment, and healthcare operations and to contact me regarding such matters as appointment reminders, insurance, and issues pertaining to clinical care. I authorize Dermatology & Advanced Skin Care to disclose appointment, medical, and financial information to:

Person authorized to receive your medical information (e.g. family member)

This authorization may be revoked in writing at any time.

Signature of Patient or Guardian

Date

Cancellation Policy for Appointments

If you are unable to keep your appointment, kindly provide 24 hours notice to avoid being assessed a cancellation fee. **Surgical appointments** require 48 hours notice. The cancellation fee ranges from **\$25 to \$100** depending on the nature of the appointment. Appointments can be cancelled by calling our office. Messages can be left 24-hour a day. Please sign below indicating that you are aware of this policy.

Signature of Patient or Guardian

Date

Financial Policies

Concerning Insurance and Assignment of Benefits

I authorize this physician to apply for benefits on my behalf for covered services rendered. I certify the information I have reported with regard to my insurance is correct. If the information is found to be incorrect, I understand that I will be responsible for providing correct information or will be responsible for the incurred costs. I further authorize the release of any necessary information, including medical information for this or any related claim to my insurance carrier. A copy of this authorization may be used in place of the original. The authorization may be revoked by me or my insurance carrier at any time in writing.

I authorize payment of all medical insurance benefits which are payable to me under the terms of my insurance policy to be paid directly to Dermatology & Advanced Skin Care for services rendered. I further authorize the release of any information needed for processing my insurance claims. A copy of this authorization may be used in place of the original. I understand and agree that I am financially responsible for charges not paid by my insurance company, including but not limited to termination of coverage at time of visit, a non-covered benefit per my insurance plan, a cosmetic procedure, or lack of referral from my primary care physician. I also understand I am responsible for any collection agency fees (30-50% of the account balance) occurred from an overdue account.

Signature of Patient or Guardian

Date

For Medicare Patients Only

I understand that in certain circumstances under Medicare law, Medicare may decide that services are not medically necessary or are cosmetic in nature. Since Medicare will deny payment for these services, I agree to be personally responsible for payment of these charges.

Signature of Patient or Guardian

Date

Dermatology & Advanced Skin Care, Inc.

Medical History

Patient: _____ Date: _____

Referring Physician: _____

Reason for Today's Visit: _____

List any medications you have used for this condition: _____

Allergies to Medication: None If YES, LIST: 1. _____ 2. _____

Other Allergies: None If YES, LIST: 1. _____ 2. _____

Current Medications: None Aspirin/Motrin/Advil Coumadin Birth Control Pills

Other Medications (Include vitamins and herbal supplements):

1. _____ 2. _____
3. _____ 4. _____

Do you have or have you ever had problems with:

- | | | |
|-----------------------------------------------------------------------------------|----------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|
| <input type="checkbox"/> YES <input type="checkbox"/> NO Arthritis | <input type="checkbox"/> YES <input type="checkbox"/> NO Heart Disease | <input type="checkbox"/> YES <input type="checkbox"/> NO Neurological Disease |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Asthma | <input type="checkbox"/> YES <input type="checkbox"/> NO Hepatitis/Liver Disease | <input type="checkbox"/> YES <input type="checkbox"/> NO Psychological Problems |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Blood Disorders | <input type="checkbox"/> YES <input type="checkbox"/> NO High Blood Pressure | <input type="checkbox"/> YES <input type="checkbox"/> NO Thyroid Disease |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Diabetes | <input type="checkbox"/> YES <input type="checkbox"/> NO HIV/AIDs | <input type="checkbox"/> YES <input type="checkbox"/> NO Received Blood Transfusions |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Gastrointestinal Disease | <input type="checkbox"/> YES <input type="checkbox"/> NO Lung Disease | |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Hay Fever | <input type="checkbox"/> YES <input type="checkbox"/> NO Kidney Disease | |

Have you had cancer (non skin)? NO YES If YES, what kind? _____

Do you drink alcohol? NO YES If YES, how many drinks per day? _____

Do you use IV drugs? NO YES If YES, what? _____

Do you smoke? NO YES

Do you bleed easily? NO YES

Do you take antibiotics prior to surgery or dental work? NO YES

List any other disease or condition we should know about: _____

List any surgical procedures you have had in the past six months: _____

Skin History:

When exposed to the sun, do you: Tan only Tan and Burn Burn

Have you ever had skin cancer? NO YES: Melanoma Squamous Cell Basal Cell

Do you have a history of any specific skin diseases NO YES If YES, what? _____

Family History (Check any of the following medical conditions that have occurred in your family):

Disease	Parent	Blood Relative	None	Disease	Parent	Blood Relative	None
Acne				Hay Fever			
Arthritis				Hives			
Asthma				Lupus			
Cancer				Melanoma			
Diabetes				Psoriasis			
Eczema				Skin Cancer			

Dermatology & Advanced Skin Care, Inc.

Medical History: Review of Systems

Patient: _____

Date: _____

Do you have or have you ever had problems with:

General

- YES NO Fever
 YES NO Weight Loss/Gain
 YES NO Night Sweats
 YES NO Extreme Fatigue

Endocrine

- YES NO Excess thirst
 YES NO Insomnia

Lungs/Respiratory

- YES NO Shortness of breath

Cardiovascular

- YES NO Chest Pains
 YES NO Palpitations
 YES NO Ankle Swelling

Psychiatric

- YES NO Depression
 YES NO Suicidal Thoughts
 YES NO Anxiety

Musculoskeletal

- YES NO Joint pain
 YES NO Back pain

ENT

- YES NO Nose Bleeds
 YES NO Ringing in ears
 YES NO Problems swallowing

Neurological

- YES NO Headaches
 YES NO Numbness
 YES NO Seizures

Eyes

- YES NO Irritation of the eyes/eyelids
 YES NO Blurred Vision

Gastrointestinal

- YES NO Diarrhea
 YES NO Constipation
 YES NO Eating problems

Lymph/Hematology

- YES NO Bleeding
 YES NO Sweating

Urinary

- YES NO Difficulty urinating
 YES NO Frequency
 YES NO Burning

Allergy/Immunology

- YES NO Dust
 YES NO Ragweed
 YES NO Moulds
 YES NO Other: _____

Skin

- YES NO Itchiness
 YES NO Skin Allergies

Pregnancy Issues

- YES NO Currently pregnant DUE DATE: _____
 YES NO Currently breast feeding
 YES NO Planning pregnancy

Completed by: Patient
 Nurse/Medical Assistant

Signed by Physician